

2003 Open Enrollment

County of San Bernardino

Employee Benefits & Services Division

Retirees

■ MEDICAL PLANS

■ DENTAL PLANS



DISCOVER
your **OPTIONS**

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This booklet is designed to help you discover your options during Open Enrollment. It is intended to highlight your benefits and does not fully represent all of the terms of your benefits plans.

Introduction

The County of San Bernardino has designed the medical and dental plan enrollment package, including this booklet, to help you better understand your enrollment options. Please read your materials carefully, and then choose the plan that best meets your needs.

Included in this booklet are brief summaries of the plans, comparison charts for convenient, at-a-glance referencing, monthly medical and dental plans premium rates, contact information, phone numbers, web sites, and answers to frequently asked questions.

As you prepare to enroll or make changes in your coverage, consider your benefits needs carefully. Think about the types and levels of coverage that you might need, both now and throughout the plan year. And don't forget to factor costs into your benefits picture.

What's New & Different in 2003

This Open Enrollment, retirees will not see benefits changes. During the rate renewal process, all carriers again quoted significant rate increases for both active employees and retirees. The County is very concerned with the escalating insurance premiums. The rising cost of healthcare is a national crisis with employers again facing double digit premium increases this year. It is expected that this trend will continue over the next several years. The Employee Benefits and Services Division is committed to seeking alternative solutions, if any, to this continuing problem.



Health Net ELECT Open Access

Retirees over 65 who do not have Medicare Parts A and B and are enrolled in ELECT Open Access will experience a 39% premium rate increase. Last year when Health Net calculated the rates for this plan option, they erroneously omitted the rate factor for prescription drugs. Once they discovered their mistake, Open Enrollment was over, so they agreed to honor the quoted rate. This year the prescription drug factor has been included in the overall rate. Please note that the 39% increase does not include any attempt by Health Net to recover lost premiums due to last plan year's error.

Medicare integrated plan premium increases were dictated by the Federal Medicare reimbursement rates. These reimbursement rates vary by geographic area and do not include coverage for prescription drugs. The lack of prescription drug reimbursement by Medicare is a large factor in the overall premium increase.

Kaiser Permanente

There are no significant benefit changes for 2003/2004. There will be an increase in premium rates; please read the premium rate schedule included in your Open Enrollment materials.



We encourage you to keep this booklet as a reference throughout the year. If you have questions, call your plan or the Employee Benefits and Services Division directly. Phone numbers and web sites are listed in the Contact Information section of this booklet.

IMPORTANT:

This booklet only highlights your benefits.

It is not a summary plan description (SPD). Official plan and insurance documents actually govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions and limitations, please refer to the SPD.

If any discrepancy exists between this booklet and the official documents, the official documents will prevail.

Blue Cross Prudent Buyer PPO Plan – California Residents Only

There are no significant benefit changes for 2003/2004. There will be an increase in premium rates; please read the premium rate schedule included in your Open Enrollment materials.

Blue Cross Blue Card Incentive Plan (PPO) – Outside California

There are no significant benefit changes for 2003/2004. There will be an increase in premium rates; please read the premium rate schedule included in your Open Enrollment materials.

DeltaPreferred Option

There are no significant benefit changes for 2003/2004. Please read the premium rate schedule included in your Open Enrollment materials.

Medicare Integrated Plans

The County will continue to offer both Kaiser Permanente's Senior Advantage Plan and Health Net's Seniority Plus to retirees with Medicare. There are no benefits changes in these plans.

Premium rates are changing, so please take the time to thoroughly read the premium rate schedule included in your Open Enrollment materials.



2003 Open Enrollment Master Schedule

Fri., Aug. 1	<p>Open Enrollment Begins</p> <p>During Open Enrollment, if you are eligible, you may:</p> <ul style="list-style-type: none">◆ Enroll in a medical and/or dental plan◆ Change medical plans◆ Drop dependents from your medical and/or dental plans◆ Add eligible dependents to your medical and/or dental plans
Wed., Aug. 6	<p>Open Enrollment Meeting 1:00 p.m. to 4:00 p.m., Behavioral Health Resource Center, 850 E. Foothill Blvd., Conference Rooms F119/F120, Rialto, CA 92376</p>
Wed., Aug. 13	<p>Open Enrollment Meeting 6:00 p.m. to 8:00 p.m., County Government Center, 385 N. Arrowhead Avenue, Flag Pole Entrance Meeting Room, San Bernardino, CA 92415</p>
Thurs., Aug. 14	<p>Open Enrollment Meeting 9:00 a.m. to 11:00 a.m., General Services Building, 777 E. Rialto Avenue, San Bernardino, CA 92415</p>
Thurs., Aug. 14	<p>Open Enrollment Meeting 2:00 p.m. to 4:00 p.m., General Services Building, 777 E. Rialto Avenue, San Bernardino, CA 92415</p>
Fri., Aug. 29	<p>Open Enrollment Ends This is the deadline to submit your Medical and/or Dental Plan Enrollment/Change Forms. Forms postmarked after this date will not be processed.</p>
Wed., Oct. 1	<p>New Plan Year Effective date of new premium rates and any changes you make to your plan elections or coverage levels. If you need help verifying eligibility or with the enrollment process, please call the County's Employee Benefits and Services Division. See the Contact Information section of this booklet.</p>
Mon., Nov. 3	<p>Enrollment Confirmation Statements will be mailed to all retirees and beneficiaries.</p>
Mon., Dec. 1	<p>Plan Identification (ID) Cards will be mailed to all retirees and their enrolled dependents. If you do not receive an ID card by December 15, 2003, please contact your medical and/or dental plan directly.</p>

Eligibility & Enrollment

Eligibility

To participate in the County-sponsored retiree plans, you must be a San Bernardino County Employees' Retirement Association (SBCERA) retiree or beneficiary receiving monthly benefits. You pay the cost of coverage and your insurance premium is deducted from your monthly retirement warrant.

Dependent Eligibility

If you are eligible to participate in the County-sponsored plans, your eligible dependents may also participate. Your eligible dependents include:

- ◆ Your legal spouse (a copy of your marriage certificate is required)
- ◆ Your unmarried children* who are:
 - Less than 19 years old
 - 19 years old, but less than 24 years old, enrolled in school as a full-time student and supported



primarily by you (birth certificate or proof of dependence and Student or Disabled Dependent of Certification Form must accompany the Medical and/or Dental Plan Enrollment/Change Form)

- ◆ 19 or more years old and supported primarily by you and incapable of self-sustaining employment by reason of mental or physical handicap. Birth certificate and student or Disabled Dependent Certificate Form with proof of physical or mental condition must accompany the Medical and/or Dental Plan Enrollment/Change Form)

* Your children include children born to you, legally adopted by you (including those children during any waiting period before the finalization of their adoption), your stepchildren, children for whom you are the legal guardian, and children you support as a result of a valid court order. Parents, grandparents, grandchildren, common-law spouses, divorced spouses, roommates, children under age 24 who marry and subsequently divorce, and relatives other than those listed above are not eligible. *(Kaiser Permanente allows coverage for grandchildren if the*

dependent child was enrolled with Kaiser Permanente prior to giving birth to the grandchild. Coverage for the grandchild may continue as long as the dependent child is covered.)

Enrollment

When you retire, you have the opportunity to continue your medical and/or dental coverage through COBRA or you may enroll in one of the County sponsored retiree plans. If you do not enroll in a retiree plan or continue your coverage when you retire, you will not be eligible to enroll in a retiree medical and/or dental plan again until the next Open Enrollment.

During Open Enrollment, you may enroll in a medical and/or dental plan, cancel your medical and/or dental plan coverage, change medical plans, and/or add/delete eligible dependents to/from your coverage. Before making changes, be sure to read your enrollment materials carefully. You will be asked to consider these plans:

Medical Plans

- ◆ Health Net ELECT Open Access HMO
- ◆ Blue Cross Prudent Buyer PPO

- ◆ Blue Cross Blue Card Incentive
- ◆ Kaiser Permanente HMO

Dental Plan

- ◆ DeltaPreferred Option

Medicare Integrated Plans

- ◆ Kaiser Permanente Senior Advantage
- ◆ Health Net Seniority Plus

If You Are Enrolling or Making Changes

TO ENROLL, CANCEL OR MAKE CHANGES, submit a completed and signed Medical and/or Dental Plan Enrollment/Change Form (with appropriate attachments, such as a marriage or birth certificate, if applicable) to the SBCERA. These are the forms contained in this booklet:

Medical Plan Enrollment/Change Form Required to enroll, cancel or make changes.

Dental Plan Enrollment/Change Form Required to enroll, cancel or make changes.

Student or Disabled Dependent Certification Form Required to enroll dependents age 19 or older (attach to a Medical and/or Dental Plan Enrollment/Change Form).

If you are enrolling for the first time or if you are making changes to your existing coverage, you must submit the appropriate forms, with any required attachments, to the San Bernardino County Employees Retirement Association (SBCERA) by August 29, 2003.

If You Are Not Making Changes

If you are not making changes to your current medical or dental coverage, do not complete a Medical and/or Dental Plan Enrollment/Change Form. Your current coverage will continue automatically.

If You Are Canceling Coverage

You may cancel coverage at any time during the year; however, if you cancel, you will not be eligible for enrollment in another retiree medical or dental plan until the next Open Enrollment. To cancel coverage, check the cancellation box in Section A of the Medical and/or Dental Plan Enrollment/Change Form, sign the form and submit it to the SBCERA.

Note: Requests to cancel dental plan enrollment are subject to the two-year enrollment period provisions.

What Happens If You Don't Submit An Enrollment/Change Form?

If you are not currently enrolled and you don't enroll during this Open Enrollment, you will have to wait until the next Open Enrollment. Also, dependent coverage will not be available to you until the next Open Enrollment. If you are currently enrolled your coverage will continue.

Medical and/or Dental Plan ID Cards

Within 8 to 10 weeks following the effective date of your coverage, you should receive an identification (ID) card from your medical and/or dental plan. You may, however, begin using your medical and/or dental plan before receiving your ID card. If you do not receive your ID card, or if you need a replacement card, call your plan's member services department.

If you have a problem accessing care, call the Employee Benefits and Services Division. See the Contact Information section of this booklet.

Open Enrollment and Confirmation Statements

Your Open Enrollment Statement, enclosed with your enrollment booklet, lists your current enrollment elections. After Open Enrollment, you will receive a Confirmation Statement verifying your 2003/2004 elections.

The Confirmation Statement will be mailed to your home and will list the plan you elected, dependents covered, and the effective date of your coverage. You may use this statement as proof of your eligibility until you receive your plan ID card.

Mid-Year Changes

You will have to wait until the next Open Enrollment to change medical and/or dental plans or coverage levels UNLESS you experience an IRS qualifying event, such as:

- ◆ You get married
- ◆ You get divorced (final decree) or legally separated
- ◆ Your spouse or dependent dies
- ◆ A child is born or placed with you for adoption or legal guardianship
- ◆ Your spouse begins or ends employment
- ◆ Your eligible dependent (child)

- begins employment
- ◆ Your eligible dependent (child) loses eligibility due to age, student status, or marital status
- ◆ Your spouse's work hours increase or decrease affecting your benefits eligibility
- ◆ Your spouse begins or returns from an unpaid leave of absence
- ◆ You relocate into or outside of a HMO network service area (such as Kaiser Permanente)
- ◆ You or your dependent becomes entitled to Medicare

During Open Enrollment you have an opportunity to enroll for coverage. If you are enrolling for the first time or making changes, be sure to submit your Medical and/or Dental Plan

If you experience an IRS qualifying event and you want to request a mid-year change, you must:

1 Complete a Medical and/or Dental Plan Enrollment/Change Form; the forms are in this booklet, are available from the Employee Benefits and Services Division, and are on the Internet at www.co.san-bernardino.ca.us/hr/benefits/default.asp

2 Attach documentation that verifies the need for a mid-year change; examples of acceptable documentation are:

- Copies of birth, death or marriage certificates
- Copies of court papers for divorces, separations or adoptions
- Copy of letter from employer verifying loss or gain of spouse's employment

Mid-year changes must be consistent with and due to the qualifying life event for which you are requesting the change, and must

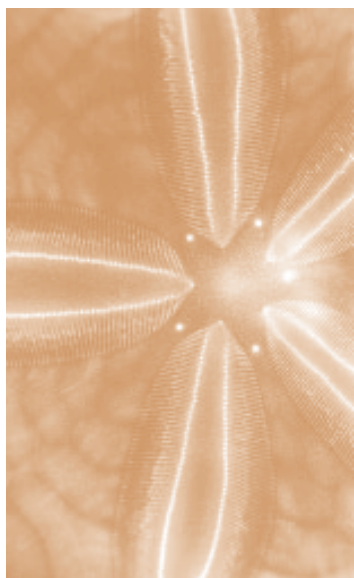
meet the guidelines of County contracts/agreements and plan documents.

Warning: The SBCERA *must* receive your Medical and/or Dental Plan Enrollment/Change Form within 30 days of the qualifying event. If you do not submit the form and verification documentation within 30 days, you could be denied the opportunity to make plan coverage changes until the next Open Enrollment.

Effective Date Of Mid-Year Changes

Dependent coverage is effective the first day of the month following the qualifying event.

Exceptions: newborns are covered on the date of their birth; children placed for adoption are covered on the date they are placed in the home. You will be billed for any premiums owed as a result of the addition of eligible dependents. If the life event results in a decrease in premiums, you will receive a refund for the premium overpayment. To reduce the time for a refund or to reduce the amount of premiums owed, you are encouraged to submit your paperwork as soon as possible. If



you have questions about mid-year changes, please call the SBCERA or the Employee Benefits and Services Division.

Continuation of Group Medical or Dental Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continuation for 18 months of medical and/or dental benefits for persons terminating enrollment in an employer group medical and/or dental plan under certain qualifying conditions.

The 18 months may be extended up to a total of 29 months if an individual is determined, for Social Security purposes, to be disabled within 60 days of the COBRA event. You are responsible for notifying the plan administrator, the County's Employee Benefits and Services Division, at [1-909-387-5552](tel:1-909-387-5552) within 60 days of the Social Security notification of disability.

If your dependents' coverage under any of the County-sponsored medical and/or dental plans should terminate, your covered dependents may

continue their coverage if they agree to pay the premium, when due, for a maximum period of 36 months if loss of their coverage is due to:

- 1 Your death
- 2 Your becoming eligible for Medicare
- 3 Legal separation or divorce from you
- 4 Your covered dependent child reaches the maximum age for coverage under the plan

Your dependents' coverage may be extended from 18 months to 36 months if a second qualifying event occurs, such as your death, divorce, legal separation, or Medicare entitlement.

As a covered retiree, you or your qualified beneficiaries (i.e., covered dependents) are responsible for notifying the Employee Benefits and Services Division of any qualifying events listed above, and for requesting COBRA enrollment for dependents if you wish to continue medical

In certain cases, your eligible dependents may continue group medical and/or dental coverage if they agree to pay the premiums, and the loss of coverage is due to a qualified change in status/life event.

and/or dental coverage.

Election to continue coverage must be given within 60 days from the date the coverage would normally terminate.

If you elect to continue coverage, coverage under the plan will be continued until the earliest of:

- 1 The date the maximum benefits are reached
- 2 The date the maximum continuation period expires
- 3 The date the person continuing coverage fails to pay the required premium when due
- 4 The date the person continuing coverage becomes eligible under another health plan upon reemployment, remarriage or attainment of Medicare eligibility
- 5 The date the employer ceases to provide any group health plan to any retiree

Plan Conversion Option: If you enroll in Blue Cross, Kaiser Permanente, or Health Net Seniority Plus, a plan conversion option is available to you. Individuals continuing

coverage will be given the opportunity to enroll in the conversion option before the date of continuation coverage under the COBRA provisions would terminate. To convert your coverage to an individual policy, please call your plan directly.

Blue Cross 1-800-288-2539

Kaiser

Permanente... 1-800-464-4000

Health Net 1-800-275-4737



Forms (and how to complete them)

You must complete the Medical and/or Dental Plan Enrollment/Change Form included in this booklet to:

- ❖ Select your medical and dental plans as a new retiree
- ❖ Change your medical and/or dental plans (not your provider)
- ❖ Add eligible dependents to your medical and/or dental plans
- ❖ Delete dependents from your medical and/or dental plans

You do not need to complete an enrollment/change form if:

- ❖ You are not making any changes to your medical and/or dental plans
- ❖ You want to change your primary care physician (PCP) or provider group; to make changes, call your plan's member services or customer service department

Section A (Medical/Dental) Check the box for the appropriate reason you are completing the form.

Section B (Medical/Dental) Check the box for the plan you are electing. Enter your previous plan.

Section C (Medical/Dental) Complete all blocks.

Section D (Medical/Dental) Complete this section only if you are enrolling in this plan for the first time or changing plans. List all dependents you want covered. For Health Net, you must enter a primary care physician and medical group number. Documentation of legal dependency is required for all dependents not previously covered by a County plan. All plans require a *Student or Disabled Dependent Certification* (included in this booklet) or verification of physical or mental handicap if the dependent child is 19 years or older. If applicable, proof of physical or mental handicap is also required at the time of enrollment.

Section E (Medical/Dental) Complete this section if you are not changing plans, but are only adding or deleting dependents. You must enter a primary care physician and medical group number if you are enrolled in Health Net. If applicable, proof of physical or mental handicap or *Student or Disabled Dependent Certification* is also required at the time of enrollment.

- Section F (Medical/Dental) Complete if applicable.
- Section G (Medical/Dental) Complete if you have other medical/dental insurance.
- Section H (Medical) Complete if anyone to be covered by this medical plan is enrolled in both Medicare Parts A and B.
- Section H (Dental) Read, sign and date.
- Sections I & J (Medical) Read, sign and date the reverse of the enrollment/change form.

Your form authorizes the SBCERA to deduct your share of the premium from your retirement warrant.

Important! By submitting a completed and signed Medical and/or Dental Plan Enrollment/Change Form, you are acknowledging that you have read and understand the terms and conditions for the plan you have chosen.

You are also acknowledging that you accept the benefits, conditions, exceptions and restrictions of the plan as defined in the summary plan description.



San Bernardino County Employee
Retirement Association (SBCERA)
348 West Hospitality Lane, Third Floor
San Bernardino, CA 92415-0014

RETIREE MEDICAL PLAN ENROLLMENT/CHANGE FORM

FOR ADMINISTRATIVE USE ONLY			
Effective Date	Month	Day	Year
Plan Code			
Group No.			
Family Account No.			

A	<input type="checkbox"/> NEW RETIREE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> CHANGE IN STATUS <input type="checkbox"/> CANCELLATION			
	B I CHOOSE THIS <input type="checkbox"/> BLUE CROSS PRUDENT BUYER PPO <input type="checkbox"/> KAISER PERMANENTE <input type="checkbox"/> Health Net ELECT Open Access HMO MEDICAL PLAN <input type="checkbox"/> BLUE CROSS BLUE CARD INCENTIVE <input type="checkbox"/> KAISER SENIOR ADVANTAGE* <input type="checkbox"/> Health Net Seniority Plus*			
Previous Medical Plan		*Medicare integrated plan. Obtain additional enrollment information from Board of Retirement.		

C RETIREE INFORMATION			
1. Social Security No.	2. Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date Of Birth Month Day Year	4. Check One: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced
5. Last Name	6. First Name	7. MI	8. For Name Change, List Former Name Here
9. Mailing Address Check Here If New Address <input type="checkbox"/>		10. Home Phone () Work Phone ()	
11. City	12. State	13. Zip Code	14. Primary Care Physician ID No./Group ID No. (Health Net HMO and Seniority Plus) Previously Visited? <input type="checkbox"/> Yes <input type="checkbox"/> No

D NEW ENROLLMENT ONLY IF YOU ARE ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED					Health Net HMO & Seniority Plus Enrollees Only	
Last Name	First Name	Social Security No.	Date of Birth	Relationship	Primary Care Physician's ID No./Group No.	Previously Visited?
Spouse		— —		<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children:		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I understand that if I do not enroll my eligible dependent(s) at this time, I will not be able to enroll my dependent(s) until the next annual open enrollment.

E ENROLLMENT CHANGES ONLY IF YOU ARE ADDING OR DELETING DEPENDENT(S) (BUT NOT CHANGING PLANS), COMPLETE THIS SECTION					Health Net HMO & Seniority Plus Enrollees Only	
Last Name	First Name	Social Security No.	Date of Birth	Relationship	Primary Care Physician's ID No./Group No.	Previously Visited?
<input type="checkbox"/> Add Spouse: <input type="checkbox"/> Delete		— —		<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add Children: <input type="checkbox"/> Delete		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete		— —		<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Physician's ID No. Group ID No.	<input type="checkbox"/> Yes <input type="checkbox"/> No

F	IF ADDING SPOUSE, SHOW DATE OF MARRIAGE	MONTH	DAY	YEAR	<input type="checkbox"/> MARRIAGE	<input type="checkbox"/> DIVORCE	<input type="checkbox"/> DEATH
	IF DELETING, SHOW DATE OF DIVORCE OR DEATH	/	/				

G	OTHER MEDICAL COVERAGE	H	MEDICARE COVERAGE
Are you or any other member of your family covered by other group medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance company _____ Policy no. _____ Spouse's employer _____ Phone number _____		List all family members enrolled in both Parts A & B of Medicare: Name (first, middle, last) _____ ID no. _____ Date of birth (month, day, year) ____/____/____ Name (first, middle, last) _____ ID no. _____ Date of birth (month, day, year) ____/____/____	

I QUALIFIED CHANGE IN STATUS

I understand that I may elect to add or delete eligible dependents to my medical plan if an IRS qualifying event occurs.

To add or delete dependents, I understand that I must submit a new *Medical Plan Enrollment/Change Form* within 30 days of a qualifying event. If I do not submit a *Medical Plan Enrollment/Change Form* within 30 days, my request may be denied. All requests must be *consistent* with the stated qualifying event.

J AGREEMENT

I hereby elect the medical plan designated in **Section B**. I have also designated in **Section D/E** my eligible dependents who are either: (1) to be added to the medical plan, or (2) to be deleted from the plan.

I authorize the County of San Bernardino to deduct from my salary or retirement allowance the amount required to cover my share of the prepayment (including any future premium increases).

I agree for myself and my dependents, effective immediately and for as long as necessary to process claims:

- To be bound by the terms and conditions of the Group Agreement, as it may be amended.
- To obtain all medical services from providers associated with the medical plan, unless the plans specifically provide otherwise.
- To authorize providers who have rendered services to me and my dependents to make medical information and records regarding those services available to the medical plan and their providers, who, in turn, may share such records among themselves. This information may also be released to appropriate government agencies.
- To complete and submit consents, releases, assignments and other documents related to protecting the medical plans' rights under the Group Agreement. This includes coordinating benefits with other group health plans, insurance policies or Medicare. I also agree to pay the cost incurred by the medical plan out of any awards, settlements or payments made to me in connection with personal injuries sustained by me or my dependents.
- To abide by the rules of binding arbitration as described in the Evidence of Coverage and Disclosure brochures for Blue Cross, Kaiser Permanente, and Health Net medical plans. Claims against the medical plans or their providers are subject to binding arbitration, excepting claims against the medical plan for the professional negligence of the medical plans' providers, after exhaustion of the medical plans' grievance procedures.

Kaiser Foundation Health Plan Arbitration Agreement:

I understand that, except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if your Group must comply with ERISA regarding certain benefit-related disputes, any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the arbitration provision is contained in the Evidence of Coverage.

Health Net Members only: I understand that any dispute or controversy, including medical malpractice that may arise regarding the performance, interpretation, or breach of the agreement between myself (and/or any enrolled family member) and Health Net, Health Net Life Insurance Company or any Participating Physician Group/Independent Physicians Association, whether arising in contract, tort, or otherwise, must be submitted to arbitration in lieu of a jury or court trial. Please sign and date this application. Your signature indicates that you have completed all requested information as accurately as possible and understand all agreements implied including your agreement to submit disputes to binding arbitration.

I hereby authorize my physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records pertaining to medical history, services rendered, or treatment given for purpose of review, investigation or evaluation of an application or a claim. I also authorize disclosure to a hospital or health care plan, employer, self-insurer or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claims or for purposes of utilization review or financial audit.

I certify that, to the best of my knowledge, all information furnished by me here is true and correct. I also certify that the names of the persons listed in Section H are enrolled in both Parts A and B of Medicare.

Retiree's Signature

Date

RETURN THIS
FORM TO

San Bernardino County Employee
Retirement Association (SBCERA)
348 West Hospitality Lane, 3rd Floor
San Bernardino, CA 92415-0014

FORM 1/MEDFORM/RETIREE/7-00

County of San Bernardino STUDENT OR DISABLED DEPENDENT CERTIFICATION

Must print in Black or Blue ink ONLY.

Retiree's Name	Social Security Number
Retiree's Medical Plan	Retiree's Dental Plan

COMPLETE ONE FORM FOR EACH DEPENDENT CHILD AGED 19 OR OVER

Dependent Name	Social Security Number
Relationship to Employee	Date of Birth

PART A	<p>Note: Full-time student status requires 8 semester/quarter units for Kaiser Permanente or 12 semester/quarter units for all other medical and dental plans.</p> <p>Please check one of the following:</p> <p><input type="checkbox"/> Dependent is 19 or more years of age and is incapable of self-sustaining employment because of a physical or mental condition. (Proof of physical or mental condition required.)</p> <p><input type="checkbox"/> Dependent is an unmarried, full-time student between the ages of 19 through 23 and is financially dependent upon employee in accordance with Internal Revenue Code Section 152. (Complete Part B)</p> <p><input type="checkbox"/> Delete the above-named dependent from my County medical and/or dental plan(s). (Attach the applicable medical and/or dental forms and <i>Benefit Plan Premium Conversion Election</i> form.)</p> <p><input type="checkbox"/> No longer a student as of _____</p> <p><input type="checkbox"/> Attained maximum age <input type="checkbox"/> Dependent Married on _____</p>
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PART B	<p>The above-named dependent is enrolled as a full-time student at:</p> <p>School Name: _____</p> <p>School Address: _____</p> <p>_____</p> <p>_____</p> <p>For the School Year ____/____ Number of Units _____ <input type="checkbox"/> Quarter <input type="checkbox"/> Semester</p>
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I certify that, to the best of my knowledge, all information furnished by me here is true and correct.

Retiree's Signature	Date
----------------------------	-------------

PLEASE RETURN THIS FORM TO: San Bernardino County Employee Retirement Association (SBCERA)
348 West Hospitality Lane, Third Floor
San Bernardino, CA 92415-0014

RETURN FORM TO

San Bernardino County Employees
Retirement Association (SBCERA)
348 West Hospitality, Third Floor
San Bernardino, CA 92415-0014

San Bernardino County Employee
Retirement Association (SBCERA)
348 West Hospitality Lane, Third Floor
San Bernardino, CA 92415-0014

**RETIREE
DENTAL PLAN
ENROLLMENT/CHANGE FORM**

FOR ADMINISTRATIVE USE ONLY			
Effective Date	Month	Day	Year
Plan Code			

A ☐ NEW RETIREE ☐ OPEN ENROLLMENT ☐ CHANGE IN STATUS ☐ CANCELLATION

B Previous Dental Plan: _____ Effective Dates - From: _____ To: _____

C RETIREE INFORMATION

1. Social Security No.	2. Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date Of Birth Month Day Year	4. Check One: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced
5. Last Name	6. First Name	7. MI	8. For Name Change, List Former Name Here
9. Mailing Address Check Here If New Address <input type="checkbox"/>		10. Home Phone ()	
		Work Phone ()	
11. City	12. State	13. Zip Code	

D NEW ENROLLMENT ONLY IF YOU ARE ENROLLING IN THIS DENTAL PLAN FOR THE FIRST TIME
OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED

Last Name	First Name	Date of Birth	Relationship
Spouse:			<input type="checkbox"/> Husband <input type="checkbox"/> Wife
Children:			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter

I understand that if I do not enroll my eligible dependent(s) at this time, I will not be able to enroll my dependent(s) until the next Open Enrollment.

E ENROLLMENT CHANGES ONLY IF YOU ARE ADDING OR DELETING DEPENDENT(S)
BUT NOT CHANGING PLANS, COMPLETE THIS SECTION

Name of family member(s) to be added or deleted:	Date of Birth	Relationship
<input type="checkbox"/> Add Spouse: <input type="checkbox"/> Delete		<input type="checkbox"/> Husband <input type="checkbox"/> Wife
<input type="checkbox"/> Add Children: <input type="checkbox"/> Delete		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Son <input type="checkbox"/> Daughter

F IF ADDING SPOUSE, SHOW DATE OF MARRIAGE. MONTH DAY YEAR
G IF DELETING, SHOW DATE OF DIVORCE OR DEATH. / / ☐ MARRIAGE ☐ DIVORCE ☐ DEATH

G OTHER DENTAL COVERAGE

Are you or any other member of your family covered by other group dental insurance? ☐ Yes ☐ No
Insurance company _____ Spouse's employer _____
Policy no. _____ Phone number () _____

H I hereby authorize my dentist, dental care practitioner, hospital, clinic, or other dental or dental-related facility to furnish any and all records pertaining to dental history, services rendered, or treatment given for purpose of review, investigation or evaluation of an application or a claim. I also authorize disclosure to a hospital or dental care plan, employer, self-insurer or insurer any such dental information obtained if such disclosure is necessary to allow the processing of any claims or for purposes of utilization review or financial audit. This authorization shall become effective immediately and shall remain in effect as long as it is necessary to enable claims processing.

I elect to enroll in (or change to) the dental plan as shown above and authorize deductions to be made from my retiree pay warrant to cover my share of the cost of enrollment as it now or as it may be in the future. I agree to remain enrolled in the program a minimum of 24 months, or until the group agreement expires, whichever is shorter.

Retiree's Signature _____

Date _____

RETURN FORM TO San Bernardino County Employee
Retirement Association (SBCERA)
348 West Hospitality Lane, 3rd Floor
San Bernardino, CA 92415-0014

RETURN FORM TO

San Bernardino County Employees
Retirement Association (SBCERA)
348 West Hospitality, Third Floor
San Bernardino, CA 92415-0014

Health Net ELECT Open Access HMO

Health Net ELECT Open Access is a Health Maintenance Organization (HMO) plan with a Point of Service (POS) provision. The HMO provision requires that you select a Primary Care Physician (PCP) from one of the Health Net Participating Physician Groups (PPG). The POS component gives you the option of seeking consultations and evaluations from any specialist within the Health Net network without a referral from your PCP.

An HMO is a medical plan that requires you to select a Primary Care Physician (PCP) to manage your medical care. With an HMO, you receive all of your

care within your PCPs network of participating physicians, hospitals, and other health care providers. Health Net ELECT Open Access allows consultations with a doctor outside of your Participating Physician Group, but within Health Net's Preferred Provider Organization (PPO) network, without a referral from your PCP.

How the Plan Works

With Health Net ELECT Open Access, you must choose a Primary Care Physician (PCP) from a Health Net Participating Physician Group when you enroll. If you also enroll dependents, each dependent can chose their own Participating Physician Group and PCP. You may not choose a specialist as a PCP. Your PCP will treat you for many medical conditions, perform preventive care services and coordinate all of your health care, including making referrals to specialists and hospitals within your Participating Physician Group. Also, under the HMO component, you are allowed to self-refer for one annual OB/GYN appointment. You must select an OB/GYN



provider who is in the same Participating Physician Group as your PCP for the visit to be covered at the HMO benefit level. Using your PCP and the HMO option is the most cost effective, lowest out-of-pocket cost way to use the plan.

However, with the Open Access component, you may see any doctor or specialist in the Health Net Preferred Provider Organization network without a referral from your PCP. When you use this option, your costs will be higher and you may have to file claim forms for certain services. This open access feature **only** covers office visits, consultation, evaluation and treatment — procedures that can be performed in the doctor's

office. Some services may require certification from Health Net. Services requiring hospitalization, outpatient surgery, maternity care and other therapeutic care must be coordinated and authorized by your PCP under the HMO option.

If you need a Health Net HMO or PPO Provider Directory, please call Health Net's Member Services at [1-800-676-6976](tel:1-800-676-6976) or [1-800-331-1777 \(Spanish\)](tel:1-800-331-1777), or use Health Net's web site at www.healthnet.com. The directory lists physicians and medical groups accepting new patients. If your current physician or medical group accepts Health Net but is not listed in the Directory, call Health Net's Member Services for assistance. Once enrolled in Health Net, you can also call Member Services to change your PCP.

Copayments For most routine HMO care, you pay a \$10 copayment. For other services, copayments range from \$10 to 50% of actual charges. For PPO Access, copayments for covered benefits are normally \$30.



Deductible Under Health Net, you pay no deductibles.

Hospitalization You are covered for all medically necessary hospitalization when admitted by your PCP.

Emergency Care If you need emergency services, you should call 911 or go directly to the nearest medical facility for treatment. Emergency Care is any otherwise covered service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a child), and believed that without immediate treatment, any of the following would occur:

- ◆ His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger)
- ◆ His or her bodily functions, organs or parts would become seriously damaged
- ◆ His or her bodily organs or parts would seriously malfunction

Emergency Care includes paramedic, ambulance and ambulance transport services provided through the "911" emergency response system. Emergency Care also includes treatment of severe pain or active labor. Health Net will make any final decisions about Emergency Care.

If you seek Emergency Care, please inform your PCP and Health Net of the locations, duration and nature of the services provided.

Out-of-Area Care If you need urgent medical care and cannot get to your PCP, call your PCP for guidance. If you are unable to contact your PCP, you should seek care for Urgently Needed Services from a licensed medical professional where you are located and notify your Participating Physician Group as soon as possible afterwards.

Claim Forms You may have to file claim forms following Emergency Care or out-of-area Urgent Care services.



Medical Transition of Care Benefit

As a new member, you are entitled to a medical review that may allow you to continue your current treatment plan due to a specific diagnosis for a specified time frame with your prior provider.

Some examples of circumstances for you or a member of your family are:

- ◆ You are in the second or third trimester of pregnancy or a high-risk pregnancy and are currently established with an Obstetrician.
- ◆ You are scheduled for surgery within 3 weeks after your effective date of coverage.
- ◆ You have documented follow-up care for surgery that was completed within 6 weeks prior to your effective date of coverage.
- ◆ You have complications resulting from surgery performed within the month prior to your effective date of coverage.
- ◆ You are presently undergoing a course of chemotherapy or radiation therapy.
- ◆ You are approved for or on a waiting list for transplant.
- ◆ You have an acute or serious chronic condition.

- ◆ You are currently receiving outpatient mental health treatment or you are currently in a chemical dependency treatment program.

If you have a transition of care issue, please complete a *Health Net Transition of Care Assistance Request Form*. You can get a copy of the form by calling Health Net Member Services at 1-800-676-6976 or 1-800-331-1777 (Spanish).

What's Covered

Refer to the Medical Plans Comparison Chart in this booklet for a summary of key covered expenses. Refer to the Health Net plan booklet for information about what is not covered under your plan. If you do not have the plan booklet, contact the SBCERA for the plan's informational packet.

How to Get in Touch with Health Net

Call Health Net's Member Services at 1-800-676-6976 or 1-800-331-1777 (Spanish), or go to Health Net's web site at www.healthnet.com for more information.

Blue Cross Prudent Buyer PPO-California Residents

The Prudent Buyer Plan is a preferred provider organization, or "PPO." A PPO is a medical plan that offers you a choice between an in-network group of providers who offer their services at discounted rates and out-of-network providers without discounted rates.

With Prudent Buyer, you may choose the level of benefits you receive based on the providers you use when you receive care. This means that you may obtain care from either an in-network (Blue Cross contracted providers and hospitals) or an out-of-network provider or hospital. It's your choice. In-network medical expenses will be subject to a \$250 calendar year individual deductible and a 20% co-insurance.

There are no changes to out-of-network benefits. If you use out-of-network providers, benefits will be 70% of usual, customary and reasonable (UCR) services for the area after the \$250 calendar year deductible. You will pay, after any required deductible, 30% and all charges above UCR. With out-of-

network providers, the plan cannot guarantee that your chosen provider will charge fees common to the area, so your out-of-pocket costs could exceed 30%.

For prescription drugs, simply present your ID card at a participating pharmacy and pay your copay. For a participating pharmacy near you, call Blue Cross' Member Services.

What's Covered and Not Covered

Refer to the Medical Plans Comparison Chart in this booklet for a list of key covered expenses. Refer to the Blue Cross plan booklet for information about what is not covered under your plan. If you do not have the plan booklet, contact the SBCERA for the plan's informational packet.

How to Get in Touch with Blue Cross

If you need information or want a Blue Cross Provider Directory, call Blue Cross' Member Services at [1-800-288-2539](tel:1-800-288-2539), or go to Blue Cross' web site at www.bluecrossca.com.



Blue Cross Blue Card Incentive-Outside California

The Blue Cross Blue Card Incentive Plan is available only to retirees who are not California residents. The Blue Card Incentive Plan is a preferred provider organization, or "PPO." A PPO is a medical plan that offers you a choice between an in-network group of providers who offer their services at discounted rates and out-of-network providers without discounted rates.

With the Blue Card Incentive Plan, you may obtain care from an extensive Blue Cross/Blue Shield provider network, or "self-refer" out of the network to a provider who does not participate in a Blue Cross/Blue Shield network. It's your choice. However, when you receive your medical care from in-network providers, the plan pays a greater benefit. Why? Because in-network providers have agreed to reduce their fees. This means you pay only your deductible and any required insurance. In-network providers may not bill you for any difference between the negotiated fee and their actual

charge. In-network covered expenses are typically paid at 80%.

If you want to see an out-of-network provider, simply make an appointment and tell them you are a member of Blue Cross' Blue Card Incentive Plan and you are using your out-of-network benefits. Your out-of-network benefits are based on what is considered usual, customary and reasonable for the area. Out-of-network covered expenses are typically paid at 70%.

For prescription drugs, simply present your ID card at a participating pharmacy and pay your copay. For a participating pharmacy near you, call Blue Cross' Member Services.

What's Covered and Not Covered

Refer to the Medical Plans Comparison Chart in this booklet for a list of key covered expenses. Refer to the Blue Cross plan booklet for information about what is not covered under your plan. If you do not have the plan booklet, contact the SBCERA for the plan's informational packet.

How to Get in Touch with Blue Cross

If you need information or want a Blue Cross Provider Directory, call Blue Cross' Member Services at **1-800-288-2539**, or go to Blue Cross' web site at www.bluecross.com.



Kaiser Permanente HMO

The Kaiser Permanente Plan is a health maintenance organization (HMO). The benefits and rates (premiums) listed in this booklet are for retirees and their eligible dependents living within the Kaiser Permanente zip code service areas of California. A list of these areas is included in the Kaiser Permanente Member Handbook. If you need a Kaiser

Permanente Handbook, call the SBCERA. If you live outside California, please call Kaiser Permanente's Member Services to verify if your zip code is eligible for enrollment. If so, contact the Employee Benefits and Services Division for information.

Kaiser Permanente providers (e.g., physicians, hospitals, etc.) contract exclusively with Kaiser Permanente at Kaiser Permanente facilities around the United States. You have access to virtually full-service, unlimited medical care at little or no cost. However, you must use Kaiser Permanente's physicians, hospitals and other approved health care providers. Otherwise, you will receive no benefits, except in a life-threatening situation. The County has also purchased additional coverage for durable medical equipment. See the durable medical equipment insert located in your Kaiser Permanente materials for specific benefit information.

What's Covered and Not Covered

Refer to the Medical Plans Comparison Chart in this booklet for a list of key covered expenses. Certain rental coverage

is provided through the Senior Advantage Program. Information is available in the Kaiser Permanente benefits packet. Refer to the Kaiser Permanente Plan booklet for information about what is not covered under your plan. If you do not have the plan booklet, contact the SBCERA for the plan's informational packet.

How to Get in Touch with Kaiser Permanente

If you need information, call Kaiser Permanente's Member Services at 1-800-464-4000, or go to Kaiser Permanente's web site at www.kp.org.

Medicare Integrated Plans — Important Information

A Medicare integrated plan combines your Medicare coverage with the benefits of an insured medical plan. In order to enroll in a Medicare integrated

plan, you must be enrolled in Medicare Parts A & B. When you enroll in a Medicare integrated plan, you assign your Medicare benefits to the medical plan. This means that to receive benefits, you must receive all your medical care through the plan's providers. *Premiums for Medicare integrated plans are typically much less expensive than purchasing a medical plan without the assignment of Medicare benefits.*

When you assign your Medicare benefits, you agree to receive all of your medical care from within the medical plan's network of providers. Your Medicare benefits will not be available to you outside the Medicare integrated plan network. As a County retiree, you have two County-sponsored Medicare integrated plans available to you:

- 1 Kaiser Permanente Senior Advantage
- 2 Health Net Seniority Plus



Conditions

- 1 You must receive all of your care from your medical plan except for emergency care and/or urgent care (while traveling outside of the service area) and authorized referrals.
- 2 You must meet these eligibility requirements:
 - ◆ You have Medicare Parts A and B
 - ◆ You live in the medical plan's service area
 - ◆ You are free of end stage renal disease
 - ◆ You are not in a hospice program
- 3 Eligible retirees/dependents may enroll in the Health Net Seniority Plus Plan at any time.
- 4 Eligible retirees/dependents may enroll in the Kaiser Permanente Senior Advantage Plan at any time if they are enrolled currently in the Kaiser Permanente HMO Plan and meet the eligibility requirements of Senior Advantage. If you are not enrolled currently in the Kaiser Permanente HMO Plan, you may enroll during Open Enrollment.
- 5 It is important to evaluate your benefits needs and the different Medicare integrated plans each year.
- 6 If you move out of the service area of your medical plan, you must "disenroll" from the Medicare integrated plan.
- 7 If you disenroll from a County-sponsored medical plan and enroll in a Medicare integrated plan or a private plan, you will be allowed to re-enroll in a County-sponsored plan ONLY during an Open Enrollment period.
- 8 The quickest way to disenroll from any Medicare integrated plan is to contact your local Social Security office and submit a disenrollment form to your health plan.
- 9 Notify the SBCERA of any enrollments or disenrollments in a Medicare integrated plan. Enrollments and disenrollments can affect the cost (premium) of your plan coverage. For example, if you are enrolled currently in Kaiser Permanente's Senior Advantage Plan and later decide to enroll in a non-County-sponsored Medicare integrated plan, you will be disenrolled automatically from Senior Advantage. In addition, a surcharge will be added to

your Kaiser Permanente basic monthly premium. Dropping the Medicare integrated plan will not cause you to become disenrolled from Kaiser Permanente, but only from the Medicare integrated plan. If you want to disenroll from the County-sponsored medical plan, you must contact the SBCERA.

Non-County-Sponsored Medicare Integrated Plans

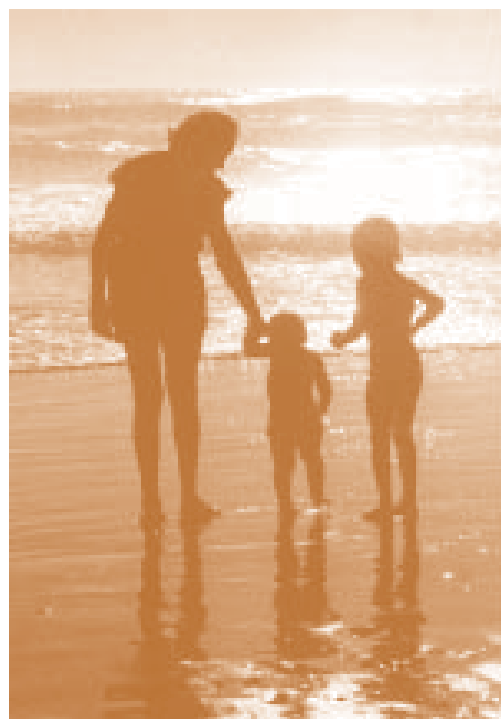
In addition to the County-sponsored Medicare integrated plan information in this booklet, you may receive information from the Centers for Medicare & Medicaid Services (CMS) about additional Medicare integrated plans available to you. If you need assistance in determining how enrolling in an individual Medicare integrated plan will affect your County-sponsored medical plan, call the Employee Benefits and Services Division at [\(909\) 387-5787](tel:(909)387-5787). If you decide to opt-out of the County-sponsored plan, be sure to notify the SBCERA that you are disenrolling.

Caution: Individual Medicare integrated plans (that are not sponsored by the County) do

not cover dependents who are not eligible for Medicare Parts A and B.

Kaiser Permanente Senior Advantage

Kaiser Permanente Senior Advantage is a health maintenance organization (HMO) and available only to retirees and their eligible dependents living within the Kaiser Permanente zip code service areas of California. A list of the Kaiser Permanente service areas is included in the Kaiser Permanente Member Handbook. If you need a Kaiser Permanente Handbook for California, call the SBCERA. If



you live in Northern California, your benefits may be different. Please call Member Services for more information. Retirees residing outside California must enroll in an individual plan beginning January 1, 2004. Please call the Employee Benefits and Services Division to verify if your zip code is eligible for enrollment.

Kaiser Permanente providers (e.g., physicians, hospitals, etc.) contract exclusively with Kaiser Permanente at Kaiser Permanente facilities around the United States. You have access to virtually full-service, unlimited medical care at little or no cost. However, you must use Kaiser Permanente's physicians, hospitals and other approved health care providers. Otherwise, you will receive no benefits, except in a life-threatening situation. The County has also purchased additional coverage for durable medical equipment. See the durable medical equipment insert located in your Kaiser Permanente materials for specific benefit information.

What's Covered and Not Covered

Refer to the *Medical Plans Comparison Chart* in this booklet for a list of key covered expenses. Refer to the plan booklet for information about what is not covered under your plan. If you do not have the plan booklet, contact the SBCERA and ask for the California plan's informational packet. If you live outside California, call Kaiser Permanente's Member Services.

How to Get in Touch with Kaiser Permanente

If you need information, call Kaiser Permanente's Member Services at **1-800-777-1238**, or go to Kaiser Permanente's web site at www.kp.org.

Health Net Seniority Plus

Health Net's Seniority Plus plan is a "HMO-style" medical plan. This means that you must receive all of your care from within a network of participating physicians, hospitals, and other health care providers.

With Seniority Plus, you choose a primary care physician (PCP) and Participating Physician Group from Seniority Plus' Provider Directory when you

enroll. You may not choose a specialist as your PCP. Your PCP will coordinate all of your health care, including making referrals to medical specialists and hospitals. To receive benefits, you must access medical care through your PCP, except for emergency services and OB/GYN appointments. You must select an OB/GYN provider that is in the same network as your PCP for the visit to be covered.

For prescription drugs, simply present your Seniority Plus ID card at a participating pharmacy and pay your co-payment. For a participating pharmacy near you, call Health Net Seniority Plus' Member Services.

What's Covered and Not Covered

Refer to the *Medical Plans Comparison Chart* in this booklet for a list of key covered expenses. Refer to the plan booklet for information about what is not covered under your plan. If you do not have the plan booklet, contact the SBCERA and ask for the plan's informational packet.

How To Get In Touch With Seniority Plus

If you need information, call Seniority Plus' Member Services at **1-800-275-4737**, or go to Seniority Plus' web site at www.healthnet.com.



DeltaPreferred Option

DeltaPreferred Option is administered by Delta Dental. DeltaPreferred Option allows you to choose to receive care from a network provider or from an out-of-network provider. It is your choice. You may change between in- and out-of-network dentists anytime without notifying Delta Dental in advance.

How the Plan Works

Retirees selecting to enroll in the DeltaPreferred Option Plan will be required to participate in the Plan for a 24-month period.

In-Network When you receive your dental care from a DeltaPreferred Option network dentist, you will pay a percent of the dentist's discounted DeltaPreferred Option rates: 0% for most preventive services, 20% for basic restorative services, and 50% for advanced restorative services. Enrollees are eligible for crowns, jackets, inlays, onlays and cast restorations only after being continuously enrolled in this plan for 12 months. This waiting period is waived if the enrollee provides proof of 12 months continuous dental coverage under another group plan prior to



enroll in this plan. To know what your cost will be in advance, you may request a preauthorization. To obtain a DeltaPreferred Option Provider Directory, please call Delta Dental at 1-800-765-6003 or log on to their website at www.deltadental.org

Out-of-Network When you receive care from an out-of-network dentist, you will pay a percentage (30% for most preventive services, 40% for basic restorative services, and 50% for advanced restorative services) of the dentist's non-discounted fees plus any charges over Usual, Customary and Reasonable (UCR) fees as established by Delta Dental. Your share of the cost will be the difference between what the plan covers out-of-network and what your out-of-network dentist is charging you. This cost will vary

by provider. *For example:* let's assume you had an out-of-network periodontic root planing and your out-of-network dentist charged \$125. If Delta Dental determined that UCR for that service was \$100, then you would pay 40% of \$100 or \$40 plus any cost over UCR or \$25. Your total out-of-pocket expense for this procedure would be \$65. If you used a network dentist, the average contracted charge for this procedure is \$85. You would pay 20% of \$85 or \$17. (Note: the numbers cited are for example purposes only. They may not be the actual rates associated with this procedure.)

Co-Insurance Co-insurance varies by procedure. However, most preventive services will be provided at no cost to you from in-network providers and out-of-network providers (within UCR limitations).

Deductible Under Delta-Preferred Option, you pay a \$50 deductible per patient per calendar year.

Emergency Care In an emergency, get the care you need. The plan will pay benefits

based on whether your emergency care was received from an in- or out-of-network dentist.

Out-of-Area Care If you need dental care away from home, call Delta Dental at 1-800-765-6003. If possible, you will be directed to an available in-network dentist. If an in-network dentist is not available, you will receive the out-of-network benefit automatically.

Claim Forms Under the DeltaPreferred Option, your network dentist will submit a standard claim form directly to Delta Dental. If your dentist needs a claim form, call the Delta Dental Claims Department at 1-800-765-6003.

If your dentist is an out-of-network dentist, Delta Dental will make claim payments directly to you. It is your responsibility to pay your dentist for services rendered.

How to Enroll

Enrolling in the plan is easy. Just fill out the *Dental Plan Enrollment/Change Form*, enclosed in your Open Enrollment

packet, and return it to the SBCERA by August 29, 2003. If you had prior dental coverage and wish to waive the 12-month waiting period for crowns, jackets, inlays, onlays and cast restorations, remember to attach proof of your prior coverage.

Call Delta Dental If You:

- ◆ Have a benefits question
- ◆ Need a provider directory
- ◆ Need a member ID card
- ◆ Have an eligibility question
- ◆ Have a claims question

What's Covered

While covered under DeltaPreferred Option, you can take advantage of comprehensive dental benefits. The plan pays benefits for covered expenses you incur while covered under the plan, subject to the maximum benefit amounts. Please refer to the Dental Plans Comparison Chart in this booklet for covered expenses.



Medical Plans Comparison Chart		
	HEALTH NET ELECT OPEN ACCESS	
	TIER ONE	TIER TWO
Annual deductible	None	None
Ambulance	No charge when medically necessary	Not covered
Choice of physician & other providers	Health Net HMO provider network	Health Net PPO provider network
Diagnostic X-rays & lab tests	No charge	Only if provided in the Physician's office. MRI, MUGA, PET and SPECT are not covered
Durable medical equipment	No charge	Not covered
Emergency room	You pay a \$50 copay (waived if admitted)	Not covered
Family planning: Infertility Services	You pay 50%; excludes GIFT, ZIFT and IVF	Not covered
Tubal Ligation	You pay a \$10 copay	Not covered
Vasectomy	You pay a \$10 copay	Not covered
Home health services	No charge when medically necessary	Not covered
Hospice	No charge when medically necessary	Not covered
Inpatient hospital care	No charge when medically necessary	Not covered
Lifetime benefits maximum	No limit	No limit
Maternity care	No charge except \$10 copay for first prenatal and postnatal visit	Not covered
Mental Health	Upgraded MHN Network OUTPATIENT: You pay \$20; up to 20 visits per year INPATIENT: No charge; up to 30 days per year	OUTPATIENT: Not covered INPATIENT: Not covered
Severe mental disorders	INPATIENT: No charge; unlimited OUTPATIENT: You pay \$10; unlimited	INPATIENT: Not covered OUTPATIENT: Not covered

	KAISER PERMANENTE HMO - CA
Annual deductible	None
Ambulance	No charge when deemed medically necessary
Choice of physician & other providers	Kaiser Permanente Medical Group and contracted facilities
Diagnostic X-rays & lab tests	No charge
Durable medical equipment	No charge
Emergency room	You pay a \$50 copay (waived if admitted)
Family planning: Infertility Services Tubal Ligation Vasectomy	You pay 50%; excludes GIFT, ZIFT and IVF You pay a \$10 copay You pay a \$10 copay
Home health services	No charge; only when medically necessary
Hospice	No charge when selected as alternative to traditional services covered by Kaiser Permanente
Inpatient hospital care	No charge for approved services obtained in a Kaiser Permanente facility or Kaiser Permanente approved facility
Lifetime benefits maximum	No limit
Maternity care	You pay a \$10 copay for 1st outpatient visit; no charge thereafter
Mental Health	INPATIENT: No charge; up to 30 days per calendar year. Unlimited for diagnosis under Mental Health Parity Act. OUTPATIENT: \$10 copay up to 20 visits; Unlimited for diagnosis under Mental Health Parity Act
Severe mental disorders	INPATIENT: No charge; unlimited days OUTPATIENT: \$10 copay; unlimited visits

M e d i c a l P l a n s C o m p a r i s o n C h a r t		
Continued	HEALTH NET ELECT OPEN ACCESS	
	TIER ONE	TIER TWO
Outpatient hospital Chemotherapy/renal dialysis Outpatient surgery	No charge No charge	Not covered Not covered
Out-of-pocket (OOP) annual maximum	\$1,500 individual; \$3,000 family	\$1,500 individual; \$3,000 family
Physician Services* Allergy Testing/Injections/Immunizations	You pay a \$10 copay	You pay a \$30 copay
Office visit	You pay a \$10 copay	You pay a \$30 copay
Surgery	No charge	Only if performed in the Physician's office
Physicals	You pay a \$10 copay	Not covered
Prostate screening	You pay a \$10 copay	Not covered
Well woman**	You pay a \$10 copay (annual)	You pay a \$30 copay (annual)
Physical & occupational therapy	You pay a \$10 copay Chiropractic not covered	You pay a \$30 copay; up to 12 visits. Chiropractic not covered
Prescription drugs (per fill)	Network Pharmacy (30-day supply) \$ 5 copay generic \$10 copay brand name \$25 copay non-formulary Mail Order Pharmacy (90-day supply) \$10 copay \$20 copay \$50 copay	Covered under Tier One benefit
Skilled nursing facility	No charge	Not covered
Speech therapy	You pay a \$10 copay	You pay a \$30 copay; up to 12 visits
Substance abuse Rehab: Detox:	INPATIENT: No charge, 30 days per calendar year OUTPATIENT: You pay \$20 copay; up to 20 visits per year INPATIENT: No charge; up to 3 days OUTPATIENT: Not covered	INPATIENT: Not covered OUTPATIENT: Not covered INPATIENT: Not covered OUTPATIENT: Not covered
Vision care (Eye Exam Only)	You pay a \$10 copay	You pay a \$30 copay

** Well woman care includes annual OB/GYN exam, breast exam, Pap smear, and mammogram (from age 50)

Continued	
Outpatient hospital Chemotherapy Outpatient surgery/renal dialysis	KAISER PERMANENTE HMO - CA No charge \$10 copay
Out-of-pocket (OOP) annual maximum	\$1,500 individual; \$3,000 family
Physician Services* Allergy Testing Injections/Immunizations	\$10 copay No charge
Office visit (physician/specialist)	\$10 copay
Surgery	\$10 copay
Physicals	\$10 copay
Prostate screening	\$10 copay
Well woman**	\$10 copay
Physical & occupational therapy	\$10 copay per visit; up to 60 days per calendar year as medically necessary
Prescription drugs (per fill)	\$10 copay - Generic \$15 copay - Brand Name 50% copay - Sexual Dysfunction/Infertility (Up to a 100-day supply; includes dental prescriptions)
Skilled nursing facility	No charge up to 100 days per benefit period
Speech therapy	\$10 copayment per visit; up to 60 days per calendar year as medically necessary
Substance abuse	INPATIENT: detoxification only; no charge when medically necessary. OUTPATIENT: you pay a \$10 copay per individual/\$5 copay per group therapy visit. TRANSITIONAL RESIDENTIAL RECOVERY SERVICES: \$100 per admission, up to 60 days/calendar year
Vision care (Eye Exam Only)	Eye exam: \$10 copay Glasses: not covered

Medical Plans Comparison Chart

	BLUE CROSS PRUDENT BUYER PPO	
	In-Network	Out-of-Network
Annual deductible	\$250 individual; \$750 family maximum	\$250 individual; \$750 family maximum
Ambulance	You pay 20% after deductible	You pay 30% after deductible when medically necessary
Choice of providers	Any Prudent Buyer physician and/or facility	You may self-refer to any licensed provider; you pay 30% after deductible plus any costs over the Usual, Customary and Reasonable (UCR) amount
Diagnostic X-rays & lab tests	You pay 20% after deductible	You pay 30% after deductible; diagnostic tests performed in conjunction with physical exams are not covered
Durable medical equipment	You pay 20% after deductible, \$5,000 per calendar year maximum benefit (includes hearing aids)	You pay 30% after deductible; \$5,000 per calendar year maximum benefit (includes hearing aids)
Emergency room	You pay a \$50 copay (waived if admitted)	You pay 30% after deductible (waived if admitted)
Family planning Infertility services Tubal ligation Vasectomy	Not covered You pay 50% after deductible You pay 50% after deductible (co-insurance does not apply to out-of-pocket maximum)	Not covered You pay 50% after deductible You pay 50% after deductible (co-insurance does not apply to out-of-pocket maximum)
Home health services	You pay 20% after deductible; up to 100 visits per calendar year maximum	You pay 30% after deductible; up to 100 visits per calendar year maximum
Hospice	You pay 20% after deductible; \$10,000 lifetime benefit	You pay 30% after deductible; \$10,000 lifetime benefit
Inpatient hospital care	You pay 20% after deductible	You pay 30% after deductible
Lifetime benefits	\$2,000,000 maximum	\$2,000,000 maximum
Maternity	You pay 20% after deductible	You pay 30% after deductible

BLUE CROSS BLUE CARD INCENTIVE

In-Network

Out-of-Network

\$250 individual; \$750 family maximum

\$250 individual; \$750 family maximum

You pay 20% after deductible (\$1,000 benefit maximum for transporting a newborn infant)

You pay 30% after deductible (\$1,000 benefit maximum for transporting a newborn infant)

Any licensed network provider

Any licensed provider

You pay 20% after deductible

You pay 30% after deductible

You pay 20% after deductible; \$5,000 per calendar year maximum benefit (includes hearing aids)

You pay 30% after deductible; \$5,000 per calendar year maximum benefit (includes hearing aids)

You pay 20% after deductible (waived if admitted)

You pay 30% after deductible (waived if admitted)

You pay 20% after deductible
You pay 20% after deductible
You pay 20% after deductible

You pay 30% after deductible
You pay 30% after deductible
You pay 30% after deductible

You pay 20% after deductible; up to 100 visits per calendar year

You pay 30% after deductible; up to 100 visits per calendar year

You pay 20% after deductible per hospice visit; and any charges over \$25 for up to four bereavement counseling visits within 12 months; \$5,000 maximum benefit hospice and counseling

You pay 30% after deductible per hospice visit; and any charges over \$25 for up to four bereavement counseling visits within 12 months; \$5,000 maximum benefit hospice and counseling

You pay 20% after deductible, plus you must precertify within 48 hours or pay a \$250 penalty

You pay 30% after deductible plus \$500 per admission; you must precertify within 48 hours or pay a \$250 penalty

\$2,000,000 maximum

\$2,000,000 maximum

You pay 20% after deductible

You pay 30% after deductible

Medical Plans Comparison Chart

Continued	BLUE CROSS PRUDENT BUYER PPO	
	In-Network	Out-of-Network
Mental Health	INPATIENT: you pay 20% after deductible; up to 30 days (175 per day maximum) OUTPATIENT: you pay 20% after deductible, plus any costs over \$40 per visit; limited to 30 visits (\$175 per day maximum). (Combined with Substance Abuse coverage; co-insurance does not apply to out-of-pocket maximum.) Severe mental and nervous disorders and serious emotional disturbances of children are not subject to limits.	You pay 30% after deductible (\$175 per day maximum)
Outpatient hospital Chemotherapy/ renal dialysis	You pay 20% after deductible	You pay 30% after deductible
Outpatient surgery	You pay 20% after deductible at network facilities	You pay 30% after deductible
Out-of-pocket (OOP) annual maximum	\$1,500 individual; no family maximum (excludes family planning, prescription drugs, outpatient mental health, outpatient substance abuse and psychotherapy/psychology testing)	\$2,000 individual; no family maximum (excludes family planning, prescription drugs, outpatient mental health, outpatient substance abuse and psychotherapy/psychology testing)
Physician services Allergy testing/ injections/immunizations	You pay 20% after deductible	You pay 30% after deductible
Office visit (physician/specialist)	You pay 20% after deductible	You pay 30% after deductible
Surgery	You pay 20% after deductible	You pay 30% after deductible
Physicals	You pay 20% after deductible	You pay 30% after deductible
Prostate screening	You pay 20% after deductible	You pay 30% after deductible
Well woman**	You pay 20% after deductible	You pay 30% after deductible

** Well woman care includes annual OB/GYN exam, breast exam, Pap smear, and mammogram (from age 40)

BLUE CROSS BLUE CARD INCENTIVE

In-Network

INPATIENT: you pay 20% after deductible, up to 30 days (\$175 per day maximum)

OUTPATIENT: you pay 20% after deductible, up to 30 days (\$25 per visit maximum)

You pay 20% after deductible

You pay 20% after deductible, plus you must precertify within 48 hours or pay a \$250 penalty

\$1,000 per individual; no family maximum

You pay 20% after deductible

You pay 20% after deductible

You pay 20% after deductible

You pay 20% after deductible (\$250 maximum benefit per calendar year)

You pay 20% after deductible

OB/GYN exam: you pay 20% (\$250 per year benefit maximum)
Pap smear: you pay 20% after deductible
Mammograms: no charge

Out-of-Network

INPATIENT: you pay 30% after deductible, up to 30 days (\$175 per day maximum)

OUTPATIENT: you pay 30% after deductible, up to 50 days (\$25 per visit maximum)

You pay 20% after deductible

You pay 30% after deductible, plus you must precertify within 48 hours or pay a \$250 penalty

\$2,000 per individual; no family maximum

You pay 30% after deductible

You pay 30% after deductible

You pay 30% after deductible

You pay 30% after deductible (\$250 maximum benefit per calendar year)

You pay 30% after deductible

OB/GYN exam: you pay 30% (\$250 per year benefit maximum)
Pap smear: you pay 30% after deductible
Mammograms: no charge

Medical Plans Comparison Chart

Continued	BLUE CROSS PRUDENT BUYER PPO	
	In-Network	Out-of-Network
Physical & occupational therapy	You pay 20% after deductible; up to 30 visits per calendar year	You pay 30% after deductible, plus any costs over \$25 per visit; up to 30 visits per calendar year
Prescription drugs	You pay a \$15 copay for a 30-day supply; brand name covered only if generic is unavailable (copay does not apply to out-of-pocket maximum) You pay 50% for lifestyle drugs, e.g. Viagra	You pay a \$15 copay for a 30-day supply; brand name covered only if generic is unavailable (copay does not apply to out-of-pocket maximum) You pay 50% for lifestyle drugs, e.g. Viagra
Mail order pharmacy (90-day supply)	You pay a \$30 copay for a 90-day supply; brand name covered only if generic is unavailable (copay does not apply to OOP maximum)	You pay a \$30 copay for a 90-day supply; brand name covered only if generic is unavailable (copay does not apply to OOP maximum)
Skilled nursing facility	You pay 20% after deductible; 100 days per calendar year at a contracting skilled nursing facility	You pay 30% after deductible; 100 days per calendar year at a contracting skilled nursing facility
Speech therapy	You pay 20% after deductible; up to 24 visits per calendar year when due to surgery, injury or organic disease	You pay 30% after deductible; up to 24 visits per calendar year when due to surgery, injury, or organic disease
Substance abuse	INPATIENT: you pay 20% after deductible (Covered for up to 30 days) (\$175 per day maximum) OUTPATIENT: you pay any costs over \$20 per visit; for a maximum of 30 visits Combined with Mental Health coverage(copays do not apply to out-of-pocket maximum) (\$175 per day maximum)	You pay 30% after deductible (\$175 per day maximum)
Vision care (Eye Exam Only)	Eye exam: you pay 20% Glasses: not covered	Not covered

BLUE CROSS BLUE CARD INCENTIVE

In-Network

Out-of-Network

You pay 20% after deductible; up to 30 visits per calendar year

You pay 20% after deductible plus any costs over \$25 per visit; up to 30 visits per calendar year

You pay a \$15 copay for generic or \$25 copay for brand name when physician required or generic is unavailable; for brand name when generic is available, you pay the \$15 copay plus the difference in cost between generic and brand. You pay 50% for lifestyle drugs, e.g. Viagra

You pay a \$15 copay for generic or \$25 copay for brand name when physician required or generic is unavailable; for brand name when generic is available, you pay the \$15 copay and cost difference between generic and brand name. You pay 50% for lifestyle drugs, e.g. Viagra. (Within CA you pay all of the above costs plus 50% of the prescription cost.)

You pay a \$30 copay; brand name covered only if generic is unavailable (copay does not apply to OOP maximum)

You pay a \$30 copay; brand name covered only if generic is unavailable (copay does not apply to OOP maximum)

You pay 20% after deductible; up to 100 days per calendar year

You pay 30% after deductible; up to 100 days per calendar year

You pay 20% after deductible when due to surgery, injury, or organic disease

You pay 30% after deductible when due to surgery, injury or organic disease

INPATIENT: You pay 20% after deductible; up to 30 days (\$175 per day maximum)

INPATIENT: You pay 30% after deductible; up to 30 days (\$175 per day maximum)

OUTPATIENT: You pay 20% after deductible; up to 50 visits (\$175 per visit maximum)

OUTPATIENT: You pay 30% after deductible; up to 50 visits (\$175 per visit maximum)

Not covered

Not covered

Medicare Integrated Plans Comparison Chart

	KAISER PERMANENTE SENIOR ADVANTAGE
Annual deductible	None
Ambulance	No charge when deemed medically necessary
Chiropractic	Limited chiropractic care available at \$10 copay
Choice of physician & other providers	Kaiser Permanente Medical Group and contracted facilities
Dental	Not covered
Diagnostic X-rays & lab tests	No charge
Durable medical equipment	No charge (does not include hearing aids)
Emergency room	\$20 copay (waived if admitted)
Family planning	\$10 copay
Home health services	No charge
Hospice	No charge
Inpatient hospital care	No charge
Lifetime benefits maximum	No limit
Maternity care	\$10 copay
Mental Health	INPATIENT: no charge up to 45 days per year; 190 days lifetime maximum. OUTPATIENT: \$10 copay; unlimited visits

HEALTH NET SENIORITY PLUS	
Annual deductible	None
Ambulance	No charge for Medicare-covered services
Chiropractic	You pay a \$10 copay
Choice of physician & other providers	Seniority Plus network provider
Dental	Not covered
Diagnostic X-rays & lab tests	No charge for Medicare-covered services
Durable medical equipment	No charge for Medicare-covered items
Emergency room	You pay a \$20 copay per visit (waived if admitted)
Family planning	Not covered
Home health services	No charge for Medicare-covered services
Hospice	You must receive care from a Medicare certified hospice
Inpatient hospital care	No charge when authorized by PCP
Lifetime benefits maximum	Unlimited
Mental Health	INPATIENT: no charge up to 190 approved days (lifetime maximum) OUTPATIENT: you pay a \$20 copay per visit

Medicare Integrated Plans Comparison Chart

Continued	KAISER PERMANENTE SENIOR ADVANTAGE
Out-of-pocket (OOP) annual maximum	\$1,500 individual; \$3,000 family maximum
Outpatient hospital Chemotherapy/renal dialysis	No charge
Outpatient surgery	\$10 copay
Physician services Allergy testing/office visit immunizations/injections (physician/specialist)/surgery/ physicals/prostate screenings Well woman*	\$10 copay No charge \$10 copay \$10 copay \$10 copay
Physical & occupational therapy	\$10 copay up to 60 days per calendar year when medically necessary
Prescription drugs (per fill)	\$10 copay - Generic \$20 copay - Brand name 50% copay - Sexual dysfunction (up to a 100-day supply)
Skilled nursing facility	No charge; up to 100 days per benefit period
Speech therapy	\$10 copay
Substance abuse	INPATIENT: no charge for medically necessary detoxification OUTPATIENT: \$10 copay individual/\$5 copay group visits REHABILITATION: you pay a \$100 copay per admission for rehab in a non-medical setting
Urgent care	\$10 copay
Vision care	\$10 copay for vision exam; \$150 allowance for eyewear every 24 months

*Well woman care includes annual OB/GYN exam, breast exams and Pap smear. It also includes mammograms for women age 40 and over.

Continued	
HEALTH NET SENIORITY PLUS	
Out-of-pocket (OOP) annual maximum	None
Outpatient hospital Chemotherapy/renal dialysis	No charge
Outpatient surgery	No charge
Physician services Allergy testing/injections immunizations/surgery/ physicals/prostate screenings Office visit Well woman*	No charge for Medicare-covered services \$10 copay No charge for Medicare-covered services
Physical & occupational therapy	No charge for Medicare-covered services
Prescription drugs (per fill)	\$10 generic -30 day supply \$20 brand name -30 day supply \$20 generic -mail order (up to 90 days) \$40 brand name -mail order (up to 90 days)
Skilled nursing facility	No charge; up to 100 days each benefit period
Speech therapy	No charge; Medicare-covered services
Substance abuse	\$20 copay for individual/group visits 1 and beyond INPATIENT: no charge OUTPATIENT: you pay a \$20 copay per visit
Urgent care	Up to a \$20 copay for each Medicare covered urgent care visit (waived if admitted)
Vision care	Annual exam: you pay a \$10 copay; Contact lenses or eye glasses after cataract surgery: no charge

*Well woman care includes annual OB/GYN exam, breast exam and Pap smears. It also includes mammograms for women age 50 and over

Dental Plans Comparison Chart

DELTA PREFERRED OPTION

Category	ADA Dental Codes	Description	In-Network (You pay...)	Out-of-Network (You pay ...plus any costs over UCR)
Preventive Care	00120	Periodic oral examination	0%	30%+
	00210	Full mouth X-ray, 1 set per year or as needed	0%	30%+
	00220	Periapical (single tooth) X-ray	0%	30%+
	09110	Emergency, palliative treatment of dental pain	0%	30%+
	09430	Office visit for observation	0%	30%+
	00460	Pulp vitality test	0%	30%+
	01201	Topical fluoride (child)	0%	30%+
	01351	Sealant (per tooth)	20%	40%+
	00470	Diagnostic models	0%	30%+
	01110	Prophylaxis (to remove tartar/stains)	0%	30%+
Restorative Dentistry	02110	Amalgam ("silver" fillings) on primary teeth: 1 surface	20%	40%+
	02120	Amalgam on primary teeth: 2 surfaces	20%	40%+
	02130-31	Amalgam on primary teeth: 3 or 4 surfaces	20%	40%+
	02140	Amalgam on permanent teeth: 1 surface	20%	40%+
	02150	Amalgam on permanent teeth: 2 surfaces	20%	40%+
	02160-61	Amalgam on permanent teeth: 3 or 4 surfaces	20%	40%+
	02330	Composite resin (white), anterior teeth only, 1 surface	20%	40%+
	02951	Pin retention	20%	40%+
	01510	Space maintainers	20%	40%+
Periodontics	04240	Gingival flap, per quadrant	20%	40%+
	04341	Periodontal scaling (deep cleaning), per quadrant	20%	40%+
	04260	Osseous surgery (reshaping bone), per quadrant	20%	40%+
	04210	Gingivectomy/gingivoplasty (gum surgery), per quadrant	20%	40%+
	04220	Gingival curettage, per quadrant	20%	40%+
	04910	Periodontal maintenance procedures		
Endodontics	03110	Pulp capping	20%	40%+
	03220	Therapeutic pulpotomy	20%	40%+
	03310	Anterior (front) teeth root canal therapy	20%	40%+
	03320	Bicuspid root canal therapy	20%	40%+
	03330	Molar root canal therapy	20%	40%+
	03920	Hemisection	20%	40%+
	03450	Root amputation (per root)	20%	40%+
	03410	Apicoectomy	20%	40%+
	03426	Periradicular surgery (each additional root)	20%	40%+
	03430	Retrograde filling (per root)	20%	40%+

Oral Surgery	07286	Biopsy of soft oral tissue		20%	40%+
	07110	Uncomplicated extraction, single tooth		20%	40%+
	07220	Extraction—impacted soft tissue, per tooth		20%	40%+
	07230	Extraction—impacted partially bony, per tooth		20%	40%+
	07240	Extraction—impacted completely bony, per tooth		20%	40%+
	09215	Local anesthesia		20%	40%+
	09220	General anesthesia (first 30 minutes)		20%	40%+
	07320	Alveoloplasty (reshape bone) per quad, without extraction		20%	40%+
	07310	Alveoloplasty (reshape bone) per quad, with extraction		20%	40%+
	07130	Removal of residual/exposed tooth roots		20%	40%+
	07510	Incision and drainage of abscess		20%	40%+
	07960	Frenulectomy (includes frenectomy or frenotomy)		20%	40%+
	07350	Vestibuloplasty		20%	40%+
Crowns and Bridges	06790	Crown—full cast high noble metal (gold)		50%	50%+
	06780	Crown—3/4 cast high noble metal (gold)		50%	50%+
	02792	Crown—full cast noble metal (silver)		50%	50%+
	02810	Crown—3/4 cast metallic		50%	50%+
	02752	Crown—porcelain fused to noble metal (silver)		50%	50%+
	02722	Crown—resin with noble metal (silver)		50%	50%+
	02710	Crown—resin (laboratory)		50%	50%+
	06930	Recement fixed partial denture		50%	50%+
	02920	Recement crown		50%	50%+
Prosthetics	05110	Complete upper denture		50%	50%+
	05120	Complete lower denture		50%	50%+
	05211	Upper partial denture—resin base		50%	50%+
	05212	Lower partial denture—resin base		50%	50%+
	05750-51	Reline upper or lower denture, laboratory		50%	50%+
	05510	Repair broken denture, no tooth damage		50%	50%+
	05410	Complete denture adjustment		50%	50%+
	05520	Replace broken tooth on denture		50%	50%+
	05710-11	Rebase complete maxillary or mandibular denture		50%	50%+
	06210	Denture pontics, cast high noble metal (gold)		50%	50%+
	06720	Denture crown, resin with high noble metal (gold)		50%	50%+
Orthodontics		Start up fees (excluding records)		N/A	N/A
		Dependent children to age 19		N/A	N/A
		Adults and covered full-time students		N/A	N/A
Deductible		Deductible is per patient per year		\$ 50	\$ 50
Calendar Year Benefit Maximum				\$1,000	\$1,000

Monthly Medical Plan Rates

Effective October 1, 2003

Plan & Coverage Level	2002 Published Rate	2003 Published Rate	Premium Difference 2002 to 2003	% Difference
HealthNet (ELECT Open Access)				
Retiree Only (under 65, no Medicare)	\$347.34	\$380.94	\$33.60	10%
Retiree Only (over 65, no Medicare)	\$549.04	\$762.14	\$213.10	39%
Retiree Only (over 65 with Medicare)	\$226.31	\$249.40	\$23.09	10%
Retiree + 1 (both under 65, no Medicare)	\$743.37	\$815.62	\$72.25	10%
Retiree + 1 (retiree under 65, no Medicare, spouse over 65, no Medicare)	\$893.35	\$1,140.05	\$246.70	28%
Retiree + 1 (retiree under 65, no Medicare, spouse over 65 with Medicare)	\$570.62	\$627.31	\$56.69	10%
Retiree + 1 (retiree over 65, no Medicare, spouse under 65 no Medicare)	\$945.07	\$1,196.81	\$251.74	27%
Retiree + 1 (retiree over 65 with Medicare, spouse under 65, no Medicare)	\$622.39	\$684.07	\$61.68	10%
Retiree + 1 (both over 65, one with Medicare, one without Medicare)	\$772.32	\$1,008.51	\$236.19	31%
Retiree + 1 (both over 65, no Medicare)	\$1,095.04	\$1,521.24	\$426.20	39%
Retiree + 1 (both over 65 with Medicare)	\$449.59	\$495.77	\$46.18	10%
Retiree + 2 (all under 65, no Medicare)	\$1,018.86	\$1,118.01	\$99.15	10%
Retiree + 2 (retiree under 65, no Medicare, spouse over 65, no Medicare)	\$1,289.38	\$1,574.72	\$285.34	22%
Retiree + 2 (retiree under 65, no Medicare, spouse over 65 with Medicare)	\$966.65	\$1,061.98	\$95.33	10%
Retiree + 2 (retiree over 65, no Medicare, spouse under 65, no Medicare)	\$1,220.55	\$1,499.20	\$278.65	23%
Retiree + 2 (retiree over 65 with Medicare, spouse under 65, no Medicare)	\$897.83	\$986.47	\$88.64	10%
Retiree + 2 (one over 65, no Medicare, one over 65, w/Medicare)	\$1,168.35	\$1,443.18	\$274.83	24%
Retiree + 2 (two over 65, no Medicare)	\$1,492.07	\$1,956.92	\$464.85	31%
Retiree + 2 (two over 65 with Medicare)	\$845.62	\$930.44	\$84.82	10%

Plan & Coverage Level	2002 Published Rate	2003 Published Rate	Premium Difference 2002 to 2003	% Difference
Health Net Seniority Plus				
Retiree Only (with Medicare)	\$128.67	\$180.99	\$52.32	41%
Retiree + 1 (1 Medicare)	\$329.39	\$615.67	\$286.28	87%
Retiree + 1 (2 Medicare)	\$254.32	\$358.95	\$104.63	41%
Retiree + 2 (1 Medicare)	\$520.01	\$918.06	\$398.05	77%
Retiree + 2 (2 Medicare)	\$520.01	\$793.63	\$273.62	53%
Blue Cross Prudent Buyer PPO Plan - Available in California Service Areas				
Retiree Only (with Medicare)	\$459.30	\$617.35	\$158.05	34%
Retiree Only (no Medicare)	\$469.96	\$631.70	\$161.74	34%
Retiree + 1 (2 Medicare)	\$927.32	\$1,247.49	\$320.17	35%
Retiree + 1 (1 Medicare)	\$938.68	\$1,262.79	\$324.11	35%
Retiree + 1 (no Medicare)	\$949.35	\$1,277.16	\$327.81	35%
Retiree + 2 (2 Medicare)	\$1,422.51	\$1,914.22	\$491.71	35%
Retiree + 2 (1 Medicare)	\$1,449.20	\$1,950.15	\$500.95	35%
Retiree + 2 (no Medicare)	\$1,467.94	\$1,975.39	\$507.45	35%
Blue Card Incentive Plan - Available to Retirees residing outside a Blue Cross Network Area)				
Retiree Only (with Medicare)	\$483.78	\$650.31	\$166.53	34%
Retiree Only (no Medicare)	\$511.76	\$671.54	\$159.78	31%
Retiree + 1 (2 Medicare)	\$976.86	\$1,314.20	\$337.34	35%
Retiree + 1 (1 Medicare)	\$1,006.07	\$1,353.52	\$347.45	35%
Retiree + 1 (no Medicare)	\$1,034.05	\$1,357.87	\$323.82	31%
Retiree + 2 (2 Medicare)	\$1,549.57	\$2,085.30	\$535.73	35%
Retiree + 2 (1 Medicare)	\$1,578.63	\$2,124.41	\$545.78	35%
Retiree + 2 (no Medicare)	\$1,599.06	\$2,100.35	\$501.29	31%

Monthly Medical Plan Rates

Plan & Coverage Level	2002 Published Rate	2003 Published Rate	Premium Difference 2002 to 2003	% Difference
Kaiser Permanente				
Retiree Only (No Medicare, under 65)	\$473.91	\$581.36	\$107.45	23%
Retiree + 1 (No Medicare, both under 65)	\$944.79	\$1,159.68	\$214.89	23%
Retiree + 2 (No Medicare, all under 65)	\$1,335.62	\$1,639.70	\$304.08	23%
Retiree Only (Senior Advantage, with Medicare)	\$98.56	\$182.11	\$83.55	85%
Retiree + 1 (Senior Advantage, both with Medicare)	\$194.08	\$361.20	\$167.12	86%
Retiree + 2 (Senior Advantage, all with Medicare)	\$289.61	\$540.28	\$250.67	87%
Retiree + 1 (Senior Advantage, one with Medicare)	\$569.44	\$760.44	\$191.00	34%
Retiree + 2 (Senior Advantage, two with Medicare, one under 65 without Medicare)	\$584.91	\$841.21	\$256.30	44%
Retiree + 2 (Senior Advantage, one with Medicare, two under 65 without Medicare)	\$960.27	\$1,240.45	\$280.18	29%
Retiree Only ("M" Coverage, with Medicare)*	\$251.02	\$324.77	\$73.75	29%
Retiree + 1 ("M" Coverage, both with Medicare)*	\$499.00	\$646.50	\$147.50	30%
Retiree + 1 (One "M" Coverage with Medicare; One Senior Advantage with Medicare)*	\$346.54	\$503.85	\$157.31	45%
Retiree over 65 (Eligible/entitled for Medicare Part A only)	\$386.58	\$454.89	\$68.31	18%
Retiree over 65 (Eligible/entitled for Medicare Part B only)	\$608.78	\$694.26	\$85.48	14%
Retiree over 65 (Eligible/entitled for Medicare Parts A and B but Medicare is unassigned to Kaiser Permanente)	\$402.74	\$454.89	\$52.15	13%

Plan & Coverage Level	2002 Published Rate	2003 Published Rate	Premium Difference 2002 to 2003	% Difference
Kaiser Permanente (Continued)				
Retiree Only (Over 65 and not eligible/entitled for Medicare Parts A and B or assignment unknown)	\$608.78	\$694.26	\$85.48	14%
Retiree + 1 (Both over 65 and eligible/entitled for Medicare Parts A and B but Medicare is not assigned to Kaiser Permanente)	\$770.13	\$906.76	\$136.63	18%
Retiree + 1 (Both over 65 and not eligible/entitled for Medicare Parts A and B or assignment is unknown)	\$1,214.53	\$1,385.50	\$170.97	14%
Retiree + 1 (One over 65 but not eligible for Medicare Parts A and B and one under 65)	\$1,079.66	\$1,272.59	\$192.93	18%
DeltaPreferred				
Retiree	\$31.92	\$37.66	\$5.74	18%
Retiree + 1	\$57.93	\$68.86	\$10.93	19%
Retiree + 2 or more	\$98.90	\$117.99	\$19.09	19%

* "M" Coverage is limited to members enrolled in Kaiser Permanente and "M" Coverage before 7/1/87.



Questions & Answers

- 1** My spouse works for the County and I am covered as a dependent under my spouse's medical plan. Do I have to enroll in one of the retiree medical plans also?

No. As a retiree, your participation in a retiree medical plan is completely voluntary. You may continue your coverage as a dependent under your spouse's County coverage. However, if you don't enroll during this Open Enrollment, you will have to wait until the next Open Enrollment to enroll (as a member) in a retiree medical plan.

If your spouse loses medical coverage under a County-sponsored medical plan because of a reduction in work hours, termination of employment, or retirement, you and your spouse might be eligible to continue group coverage through COBRA. Also, if your covered spouse retires, your spouse will have 30 days to elect coverage as a retiree. Your spouse may then enroll you as a covered dependent.

- 2** If my spouse works for the County, may I enroll in a retiree medical plan and be a dependent on my spouse's County medical plan?

No. The retiree medical plans are administered by the County of San Bernardino. County employees, retirees and eligible dependents may not be covered by two County-sponsored medical plans at the same time.

- 3** Do I pay any portion of the cost of my medical coverage?

Yes. You pay the full monthly insurance premium for medical plan coverage.

- 4** What should I do if the premium for my medical plan coverage is not being deducted or is incorrect?

When you enroll in a medical plan or make changes to your coverage, you should check your retirement warrant carefully to verify that the proper deduction is being taken. If the deduction is not being taken or is incorrect, contact the SBCERA immediately and tell them about the discrepancy.

5 What happens if I don't continue my medical coverage when I retire?

When you retire, you have 30 days to elect to continue your medical coverage. If you do not elect to continue your medical coverage when you retire, or you discontinue coverage after retirement, you will not be eligible to enroll again until the next Open Enrollment.

6 May I switch medical plans when I retire?

No. Unless you move out of your plan's service area (see question 12), you may switch to another medical plan ONLY during Open Enrollment.

7 When may I add new eligible dependents to my coverage?

You may enroll your eligible dependents (i.e., newborn, newly adopted child, new spouse, or stepchild) within 30 days of the date of birth, marriage, custody, etc.

To enroll your eligible dependents, you must submit a Medical Plan Enrollment/Change Form (with any required attachments and verifications) within 30

calendar days. You may add dependents only during Open Enrollment unless you experience a qualified change in status.

New dependent coverage is effective the first day of the month following the event.

Exceptions: newborns are covered on the date of their birth; children placed for adoption are covered on the date placed in the home. If you have questions regarding coverage dates or cost, please call the SBCERA or County Employee Benefits and Services Division.

8 What is "Open Enrollment?"

Open Enrollment is a time set aside each year when you may enroll in a plan, change plans, cancel coverage, add eligible dependents to or delete dependents from your plan.

9 What happens to my dependents' coverage if I die?

If your beneficiaries continue to receive a retirement warrant, they may continue to participate in the retiree medical plan. If they are not eligible for a retirement warrant, they may elect COBRA (continuation coverage).





10 When does a dependent lose eligibility?

Here are some examples of when a dependent loses eligibility (see Dependent Eligibility section of this booklet):

- ◆ Your child is 19 or more years old and ceases to be a full-time student
- ◆ Your child marries
- ◆ Your child attains age 24 (exception: a disabled child)
- ◆ The final divorce decree or legal separation document is granted

Your former spouse must be deleted from your plan coverage even if the divorce settlement requires you to provide coverage. Your ex-spouse will be eligible for COBRA if you provide notice of your divorce within 30 days of the event date. See COBRA section of this booklet.

11 Do I have to notify anyone when a dependent becomes ineligible?

Yes! You are responsible for notifying the SBCERA within 30 days of the date your dependent becomes ineligible. If you do not notify the SBCERA, you could be liable for any claims paid or services rendered on behalf of an

ineligible dependent.

12 If I am enrolled in a HMO, do I have to change medical plans if I move outside the service area of my current HMO?

Yes. If you move outside the service area of your plan, you will be required to enroll in another County-offered medical plan within 30 calendar days after the move. Until you change your enrollment, you will only be covered under the "Out-of-Area Emergency" provision of your current HMO.

13 What should I do if I become (or a dependent becomes) eligible for Medicare?

Three months before your 65th birthday, or when a question of eligibility comes up, you should:

- ◆ Call the Social Security office regarding enrollment and medical insurance benefits
- ◆ Call San Bernardino County Employee Benefits and Services Division at 1-909-387-5787 for medical insurance options
- ◆ Send a copy of your Medicare card with a letter listing your Medicare benefit effective date to the SBCERA

14 Who determines if I am eligible for Medicare?

Eligibility is determined by the Social Security Administration. If you are not receiving monthly Social Security payments, apply for Medicare through your local Social Security office no later than three months before your 65th birthday. If you do not apply at that time, there could be a delay in your Medicare coverage and your retiree medical premium costs could be higher.

15 How often are changes made to the medical plans and monthly premium rates?

Medical plan provisions, costs and subsidies paid by the SBCERA are subject to change each year or as determined by the terms of the contract between the County and the medical insurance carrier.

16 Do I have to submit claim forms?

For most plans, you will need to submit claim forms only when you obtain services from out-of-network providers and pharmacies, including all emergency or urgent care visits. To have your claim processed promptly, the

claims adjuster must have complete information regarding the medical services received as well as who received them. This includes your Social Security number.

17 Who may I call for additional information?

You may call your medical plan, the County's Employee Benefits and Services Division, or the SBCERA. See the Contact Information section of this booklet for telephone numbers and web site addresses.



Contact Information

Employee Benefits and Services Division

Address

157 West Fifth Street
First Floor
San Bernardino, CA 92415-0440

Phone

Web Site

www.sbcounty.gov/hr/benefits

www.co.san-bernardino.ca.us/hr/benefits/default.asp

Employee Benefits and Services Representatives:

◆ DeltaPreferred	1-909-387-5831
◆ Blue Cross Prudent Buyer PPO	1-909-387-9675
◆ Blue Cross Blue Card Incentive	1-909-387-9675
◆ Kaiser Permanente	1-909-387-5556
◆ Kaiser Permanente Senior Advantage	1-909-387-5556
◆ Health Net ELECT Open Access	1-909-387-9674
◆ Health Net Seniority Plus	1-909-387-9675

Providers

◆ Blue Cross Prudent Buyer PPO	P.O. Box 4089 Woodland Hills, CA 91365	1-800-288-2539	www.bluecrossca.com
◆ Blue Cross Blue Card Incentive	P.O. Box 4089 Woodland Hills, CA 91365	1-800-288-2539	www.bluecross.com
◆ DeltaPreferred	P.O. Box 7736 San Francisco, CA 94120	1-888-765-6003	www.deltadentalca.org
◆ Kaiser Permanente	Kaiser Permanente Foundation Health Plan P.O. Box 7102 Pasadena, CA 91109	1-800-464-4000	www.kp.org
◆ Kaiser Permanente Senior Advantage	Kaiser Permanente Foundation Health Plan P.O. Box 7102 Pasadena, CA 91109	1-800-777-1238	www.kp.org
◆ Health Net ELECT Open Access	Health Net P.O. Box 9103 Van Nuys, CA 91409-9103	1-800-676-6976	www.healthnet.com
◆ Health Net Seniority Plus	Health Net P.O. Box 10198 Van Nuys, CA 91409-0198	1-800-275-4737	www.healthnet.com

Helpful Resources and Referral Services

American Association of Retired Persons	1-800-424-3410	
American Heart Association	1-800-242-8721	
American Cancer Society	1-800-227-2345	
HCFA (for Medicare information)	1-410-786-3000	www.hcfa.gov

San Bernardino County Employee's Retirement Association (SBCERA)

348 West Hospitality Lane	1-909-885-7980	www.sbcera.org
Third Floor		
San Bernardino, CA 92415-0014		